North Carolina Industrial Commission

REPORT OF EARNINGS

IC File # _____

Emp. Code # _____

Carrier Code # _____

Carrier File # _____

The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act Employer FEIN _____

(EMPLOYER/INSURANCE CARRIER TO COMPLETE THIS SECTION)

Employee's Name	Employer's Name ( ) Telephone Number
Address	Employer's Address City State Zip
City State Zip	Insurance Carrier
( ) ( )	
Home Telephone Work Telephone	Carrier's Address City State Zip
☐M ☐F / /	( ) ( )
Social Security Number Sex Date of Birth	Carrier's Telephone Number Fax Number

To Employees: The Employer/Insurance Carrier periodically needs to verify your continuing eligibility for workers' compensation benefits and to update their records. **You are required to complete Page 2 of this Report of Earnings and return it to the insurer or employer address provided on page 2 of this form within 15 days after receipt of this form, even if you have no earnings.**

****YOUR WORKERS' COMPENSATION BENEFITS MAY BE SUSPENDED IF YOU FAIL TO COMPLETE THIS REPORT IN A TIMELY MANNER.****

NOTICE TO EMPLOYEES RECEIVING WORKERS' COMPENSATION

When you are receiving weekly workers' compensation benefits, YOU MUST REPORT ANY EARNINGS YOU RECEIVE TO THE INSURANCE CARRIER (OR EMPLOYER IF THE EMPLOYER IS SELF-INSURED) THAT IS PAYING YOU THE BENEFITS. "Earnings" include any cash, wages or salary received from self-employment or from any employment other than the employment where you were injured. Earnings also include commissions, bonuses, and the cash value for all payments received in any form other than cash (e.g., a building custodian receiving a rent-free apartment). Commissions, bonuses, etc., earned before your disability do not constitute earnings that must be reported.

You must report any work in any business, even if the business lost money or if profits or income were reinvested or paid to others.

Your endorsement on a benefit check or deposit of the check into an account is your statement that you are entitled to receive workers' compensation benefits. Your signature on a benefit check is a further affirmation that you have made no false claims or statements or concealed any material fact regarding your right to receive workers' compensation benefits.

MAKING FALSE STATEMENTS FOR THE PURPOSE OF OBTAINING WORKERS' COMPENSATION BENEFITS MAY RESULT IN CIVIL AND CRIMINAL PENALTIES.

TIME PERIOD COVERED BY THIS REPORT: _____ to _____
(Employer/Insurance Carrier must complete)

FORM 90

NORTH CAROLINA INDUSTRIAL COMMISSION
4319 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-4319
MAIN TELEPHONE: (919) 807-2500
OMBUDSMAN: (800) 688-8349

EMPLOYEE: COMPLETE SECTION BELOW

(1) Did you receive earnings from work during the time period indicated on Page 1? ☐ YES ☐ NO	(2) Did you work for a business or any person during that time period? ☐ YES ☐ NO

(3) If you answered **NO** to both questions 1 and 2, **sign and return** the form to the insurance carrier or to the individual identified by the insurance carrier or employer listed below.

(4) If you answer **YES** to either question, **complete item 5 below,** sign and return the form to the insurance carrier or to the individual identified by the insurance carrier or employer listed below. For the purposes of this statement, "Gross Earnings" include all pre-tax earnings, bonuses, commissions, and/or the cash value of any payment received in any form other than cash.

(5) 1st Employer or Business Name (include self-employment):

Location: _____
Dates worked: _____
Gross Earnings: _____

Next Employer or Business Name (include self-employment):

Location: _____
Dates worked: _____
Gross Earnings: _____

Attach additional page(s) if necessary.

Employee Signature: _____ **Date:** _____.
(Required)

NOTICE TO EMPLOYEE:

1. Failure to report earnings as defined herein may subject you to criminal prosecution and civil liability including the suspension or forfeiture of your benefits. This form must be signed and returned to the insurance carrier listed below even if you have no earnings.

2. If the Commission suspends benefits for failure to complete and return a Form 90 Report of Earnings, the self-insured employer, insurance carrier or third party administrator shall immediately reinstate benefits to the employee with back payment as soon as the Report of Earnings is submitted by the employee.

3. If benefits are not immediately reinstated, the employee should submit a written request for an Order from the Executive Secretary instructing the employer or insurance carrier to reinstate benefits. An application for reinstatement of benefits should be addressed to North Carolina Industrial Commission, Office of the Executive Secretary, 4333 Mail Service Center, Raleigh, NC 27699-4333.

Insurance carrier or Employer must list the name and address below of the person to whom this form must be returned and mail this form to the employee by certified mail return receipt requested, and include a self-addressed stamped envelope for the return of the Form.

Name: _____.

Address: _____.
City State Zip

NOTICE TO INSURER OR EMPLOYER:

Any person who willfully makes a false statement or representation of a material fact for the purpose of denying or assisting another in denying any benefit or payment under the Workers' Compensation Act shall be guilty of a Class 1 misdemeanor if the amount at issue is less than $1000. Violation is a Class H felony if the amount at issue exceeds $1000. Any person who threatens an employee with criminal prosecution under the provisions of the Act for the purpose of coercing or attempting to coerce an employee into agreeing to compensation under the Act shall be guilty of a Class H felony.

FORM 90

NORTH CAROLINA INDUSTRIAL COMMISSION
4319 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-4319
MAIN TELEPHONE: (919) 807-2500
OMBUDSMAN: (800) 688-8349